

**State of Tennessee
Department of Health**

TENNESSEE MASSAGE LICENSURE BOARD

**227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

**1-800-778-4123, ext. 32111
615-532-3202, ext. 32111**

<http://Tennessee.gov>



Application and Procedures for Licensure

Massage Therapist



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TN 37243

TENNESSEE MASSAGE LICENSURE BOARD
1-800-778-4123 ext. 32111
(615) 532-3202, ext. 32111
LICENSURE APPLICATION INSTRUCTIONS AND CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for issuance of a Tennessee license to practice. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

ALL APPLICANTS MUST COMPLETE ITEMS 1-10		DONE
1.	Complete, sign, have notarized and mail the application pages 1 through 6.	_____
2.	Submit a certified copy of your birth certificate or other equivalent document <u>notarized</u> (i.e.: photocopy of passport).	_____
3.	Attach to the application in the space provided a clear, Front Faced, recognizable, recently taken within the last twelve (12) months passport type photograph of yourself.	_____
4.	Submit two (2) original signed letters from health care professionals attesting to your personal character & professional ethics, must be within the preceding twelve (12) months.	_____
5.	Submit with your application a check or money order in the amount of \$110.00 made payable to the State of Tennessee.	_____
6.	Complete and mail Attachment 2 to each state, country, or province in which you hold, or have ever held a <u>license, certificate, or permit</u> to practice <u>any</u> health profession.	_____
7.	Request verification of successful completion of the examination offered by the NCBTMB be sent to the Board directly from the NCBTMB.	_____

8. Complete and mail Attachment 1 to the school(s) in which you completed a massage, bodywork, and or somatic therapy curriculum of no less than five-hundred (500) hours. Schools must be approved by the Tennessee Higher Education Commission or its equivalent in another state. Transcript from out of state Massage Therapy schools must show two – hundred (200) hours of Anatomy and Physiology, two-hundred hours of Massage Therapy, and one-hundred (100) hours of Allied Modalities. A course description with hours taken in each course may be submitted with the school transcript. _____
9. You must complete and return Attachment 3 – Jurisprudence Questionnaire. _____
10. You must complete and return the Mandatory Practitioner Profile Questionnaire. _____
11. Criminal Background Check (See Massage Therapists Instructions-Page 4 of 4 Pages) _____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board office, in writing, immediately.

1. **ALL APPLICATION FEES ARE NON-REFUNDABLE.**
2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process must be mailed directly to:

**Massage Licensure Board
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

**For Federal Express or Special Courier:
Massage Licensure Board
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37228**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board office every consideration in this matter.
4. **We will discuss application status with the applicant or applicant's spouse only.** Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.
5. If necessary documentation has not been received when your application has been received by the Board office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board office sixty (60) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.
6. Absent any complicating factors, the average application processing time is **eight weeks**. Once the application is completed, your file will be promptly reviewed and an initial licensure determination made. You will be promptly notified by letter of the initial determination.
7. It is recommended that you **do not** make arrangements to accept employment as a massage therapist or open a massage establishment in Tennessee until you are granted a license or authorization from the Board.

Thank you for your cooperation. We will make every effort to process your application in an expeditious and efficient manner.

**PLACE
FULL FACE,
PASSPORT SIZE
PHOTOGRAPH
HERE**



For Office Use Only	
Fee Codes	
2680-001-	\$ 25.00
2680-001-	\$ 75.00
2680-006-	\$ 10.00
TOTAL	\$110.00

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
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TENNESSEE MASSAGE LICENSURE BOARD
1-800-778-4123 ext. 32111
(615) 532-3202, ext. 32111
www.tennessee.gov

MASSAGE THERAPIST LICENSURE APPLICATION

APPLICANT: Read all instructions carefully and complete all portions applicable to you. **Please type or print in ink.** If a question does not apply to you place a **N/A** in the appropriate space. Do not leave any sections unanswered.

ALL APPLICATION FEES ARE NON-REFUNDABLE

**ATTACH A CHECK OR MONEY ORDER HERE IN THE AMOUNT OF \$110.00 FOR MASSAGE THERAPIST LICENSE.
MAKE CHECK PAYABLE TO:**

THE STATE OF TENNESSEE

PERSONAL INFORMATION

Name: _____
 First Middle Last Maiden

Social Security Number: _____ - - Date of Birth: _____

Mailing Address: _____ County (TN Applicants Only); _____

 _____ Phone: Home: (_____) _____

 _____ Work: (_____) _____

 _____ Sex: (optional - for statistical purposes only)

Place of Birth: _____ Female _____

 _____ Male _____

U.S. Citizen: Yes _____ No _____

EDUCATIONAL AND EMPLOYMENT INFORMATION

Please provide the following information for all educational institutions you have attended beyond junior high or middle school. Use the back of this page if you need additional space.

High School

From: _____ To: _____
Mo/Yr Mo/Yr Educational Institution Location

College/University

From: _____ To: _____
Mo/Yr Mo/Yr _____ Educational Institution _____ Location _____

Trade School or Massage Bodywork Training

From: _____ To: _____

Mo/Yr	Mo/Yr	Educational Institution	Location
-------	-------	-------------------------	----------

Please complete your entire employment history starting with the most current position first. Use the back of this page if you need additional space.

DATES

LOCATION

POSITION AND DUTIES

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

From: _____ To: _____
Mo/Yr Mo/Yr (City) (State) _____

LICENSURE AND CERTIFICATION INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed permitted or certified as a Massage Therapist. Submit a copy of **Attachment 2** to all such states, countries, or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List below all states countries or provinces in which you hold or have ever held a license, certification or permit as a health professional other than a Massage Therapist. Submit a copy of **Attachment 2** to all such states, countries or provinces regarding such licensure, certification or permit. Use the back of this page if you need additional space.

STATE	PROFESSION	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List below any memberships you have in any massage therapy related organization or association and the length of time you have been a member.

ORGANIZATION/ASSOCIATION	LOCATION	DATE OF MEMBERSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- | | | |
|--|------------|-----------|
| | Yes | No |
| 1. If you have taken and passed the National or International Certification Board of Therapeutic Massage and Bodywork examination you must download the score transfer form at www.ncbtmb.com And have the Chauncey Group to submit a verification to the Tennessee Massage Licensure Board.
If you have not taken the National exam do not submit the application. | _____ | _____ |
| 2. Have you ever previously applied for a massage therapist license or a massage establishment license in Tennessee? | _____ | _____ |

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative**, attach an explanation on a separate sheet. **In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:
 - a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and
 - b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
 - c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.
2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopaedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.
3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.
4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.
5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:

YES NO

1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?

 - a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?

 - b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION CONTINUED

QUESTIONS:	YES	NO
2. Do you currently use chemical substances?	_____	_____
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?	_____	_____
3. Are you currently engaged in the illegal use of controlled substances?	_____	_____
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?	_____	_____
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?	_____	_____
5. If you have ever held or applied for a license or certificate to practice massage therapy in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____
6. If you have ever had staff privileges at any hospital or health care facility have they ever been revoked, suspended, curtailed, restricted, limited or otherwise disciplined or voluntarily surrendered under threat or restriction or disciplinary action?	_____	_____
7. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
8. Have you ever been rejected or censured by a professional society?	_____	_____
9. In relation to the performance of your professional services in any profession:		
a. Have you ever had a final judgment rendered <u>against</u> you; or	_____	_____
b. Have you ever had settlement of any legal action rendered <u>against</u> you; or	_____	_____
c. Are there any legal actions pending <u>against</u> you or to which you are a party?	_____	_____
10. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?	_____	_____

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC

AFFIDAVIT AND RELEASE

I, _____, of _____, _____,
(Applicant's Name) (City) (State)

being duly sworn and identified as the person referred to in this application and signed photos, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include an interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications;

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

AUTHORIZE I hereby authorize release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

In order to comply with federal statutes, the Board of Massage Licensure is obligated to inform each applicant or licensee from whom it requests a social security number that disclosing such number is mandatory in order for this Board to comply with the requirements of the federal Healthcare Integrity and Protection Data Bank and/or the National Practitioner Data Bank. If the Board is required to make a report about one of its applicants or licensee to either or both of these data banks, it must report that individual's social security number. This application will not be complete if the social security number is omitted. The number will be used for identification purposes and for such other purposes as are allowed by state and federal law.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

SIGNATURE

DATE

Sworn to before me, this _____ day of _____, _____.

NOTARY PUBLIC

Affix Seal Here

My Commission expires _____



STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

TENNESSEE MASSAGE LICENSURE BOARD

1-800-778-4123 ext. 32111

(615) 532-3202, ext. 32111

EDUCATION VERIFICATION

APPLICANT: Supply the information requested in the box below, and then mail this entire form to the educational institution(s) where you completed your five hundred (500) hour massage therapy curriculum. Transcript from out of state Massage Therapy schools must show two – hundred (200) hours of Anatomy and Physiology, two-hundred hours of Massage Therapy, and one-hundred (100) hours of Allied Modalities. A course description with hours taken in each course may be submitted with the school transcript. **NOTE:** Most educational institution(s) require a fee, so you may want to contact the institution(s) before mailing this form. If you attended more than one educational institution, please send copies of this form to each one you intend to rely upon in obtaining licensure.

TO WHOM IT MAY CONCERN:

I am applying for a license to practice as a massage therapist in the State of Tennessee. The Massage Licensure Board requires verification of educational attainment. Please forward an original transcript bearing the institution's official seal to the Board's address below.

Applicant's Full Name: _____
(Last) (First) (Middle/Maiden)

Applicant's Address: _____

Applicant's Social Security Number: _____ - _____ - _____

Applicant's Student Identification Number: _____

Year of Graduation: _____

Degree Conferred: _____ Date Degree Conferred: _____

Please forward an original graduate transcript bearing the institution's official seal to:

**Massage Licensure Board
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

Thank you for your cooperation and prompt response.

Applicant's Signature

Date



Name of State where
form is to be mailed:

**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

**TENNESSEE MASSAGE LICENSURE BOARD
1-800-778-4123 ext. 32111
(615) 532-32111**

CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in each state where you hold or have ever held a license to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Type or Print In Ink)

I, the undersigned applicant, was granted a license/certificate to practice _____ with (check one)	
(Profession)	
<input type="checkbox"/> License / <input type="checkbox"/> Certificate / <input type="checkbox"/> Registry number _____ on _____ in the State of _____	(Date)
The Tennessee Massage Therapy Board requests that I submit evidence of the current status of that license/certification in your state.	
You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Massage Therapy Board.	
Date: _____	Applicant's Signature _____
	Applicant's typed or printed name _____

To Be Completed By Administrative Office of State Licensure Board

Name In Full As It Appears On License/Certificate or Permit:		
_____ (First)	_____ (M.I.)	_____ (Last)
License/Certificate/Permit Number: _____ Profession: _____		
Date Issued: _____		
Basis of issuance: _____ Endorsement/Reciprocity with _____		
(Check One)	(State)	
_____ Written Examination _____		
(Name of Exam)		
The License is currently active and registered? ____ Yes ____ No		
Is there any derogatory information on file? ____ Yes ____ No If yes, Please attach supporting documentation.		
_____ Authorized Signature	_____ Title	_____ Date

State Board: Please return this form to: **Massage Licensure Board
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243**

**TENNESSEE MASSAGE LICENSURE BOARD
JURISPRUDENCE QUESTIONNAIRE**

Name _____ Social Security # _____

Circle the correct answer and return this questionnaire with your application to the Board.

- | | | | |
|-----|------|-------|---|
| 1. | True | False | A license to perform massage therapy is not required when the client provides compensation to the massage therapist. |
| 2. | True | False | An adequate waiting area for all clients is mandatory for licensed massage establishments. |
| 3. | True | False | If linens remain clean, they may be used for more than one (1) client. |
| 4. | True | False | If a client objects, he/she does not have to be draped. |
| 5. | True | False | Licenses must be renewed every year before December 31 st . |
| 6. | True | False | Enclosing proof of completing annual continuing education requirements with the licensure renewal form is not necessary. |
| 7. | True | False | There will be no consequences for failure to renew a license if the Board forgets to send a renewal form. |
| 8. | True | False | Submitting an "affidavit of retirement" instead of a notarized letter is the proper way to retire a license. |
| 9. | True | False | Reinstating a license that has been retired for two (2) or more years will result in the licensee having to submit proof of continuing education. |
| 10. | True | False | Ten (10) hours of massage therapy related continuing education are required in a calendar year. |
| 11. | True | False | The Tennessee Medical Association is not a pre-approved continuing education course provider. |
| 12. | True | False | Each licensee must retain proof of completing continuing education requirements for four (4) years. |
| 13. | True | False | If an establishment's license is displayed, it is not necessary to display the licenses of the massage therapists. |
| 14. | True | False | Changing a licensee's name and/or address can be accomplished by calling the Board's toll-free phone number. |
| 15. | True | False | Advertising that massage therapy cures arthritis is permitted. |

16.	True	False	A recording or copy of every advertisement must be retained by the licensee for two (2) years.
17.	True	False	Refusing to comply with or allow a Board authorized inspection constitutes grounds for revocation or suspension of a license.
18.	True	False	Although massage therapy is considered to be one of the healing arts, massage therapists are not considered to be primary care providers.
19.	True	False	Separate rest rooms are required for men and women in all massage establishments.
20.	True	False	Massage tables must be cleaned as often as necessary, or at least once per day.
21.	True	False	A massage establishment license is not required if in a beauty shop that has a business license.
22.	True	False	A female massage therapist may perform breast massage on a male client.
23.	True	False	Any location within a health care professional's office dedicated to and maintained for the use of a massage therapist who performs massage therapy services to the patients of the facility must be licensed as a massage establishment.
24.	True	False	No continuing education is required in the year of graduation from massage school.
25.	True	False	Every massage therapist is responsible for complying with the rules of the Tennessee Massage Licensure Board.
26.	True	False	The school is responsible for teaching me every thing I need know about massage rules and laws.
27.	True	False	It is the individual massage establishment owners' responsibility to know and comply with the rules of the Tennessee Massage Licensure Board.

KR/G4015346/MTB



TENNESSEE DEPARTMENT OF
HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

**PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq.,
LAWS OF TENNESSEE**

FOR
LICENSED HEALTH CARE PROVIDERS

FOREWORD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: <http://tennessee.gov/health>.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

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SECTION I: GENERAL INSTRUCTIONS

- ▶ **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- ▶ **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- ▶ **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.**
- ▶ **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- ▶ **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the “Does not apply” box.**
- ▶ **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- ▶ **You may have completed a similar questionnaire for another state’s licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- ▶ **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- ▶ **Mail the completed ORIGINAL profile questionnaire within thirty (30) days of its receipt by the provider to:**

**Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202**

- ▶ **Keep a copy of the questionnaire for your records.**

✓CHECKLIST

Before you mail your questionnaire:

- ☐ Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?
- ☐ Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?
- ☐ Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the “Does not apply” box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in “N/A” for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a “yes” answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer “yes” to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board’s web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ License # _____
Profession _____

SECTION III:

**HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243**

I. PRACTITIONER DATA

- A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____
B. SOCIAL SECURITY NUMBER: _____ (This will not be published as part of the profile or website).

- C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

(LAST) (FIRST) (MIDDLE AND MAIDEN NAME)
(IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

- D. MAILING
ADDRESS:

(STREET AND NUMBER)

(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

(PRACTICE NAME)

(STREET AND NUMBER)

(CITY) (STATE) (ZIP CODE)

- E. TELEPHONE: (_____) _____ (This will not be published as part of the profile or the web site).

- F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____
2. _____

- G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____
2. _____

Practitioner's Name _____ License # _____
 Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

- A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

- B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ License # _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ☐ NO ☐

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ☐ NO ☐

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

Name of Hospital	City/State
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ License # _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ☐ NO ☐
If "YES", list each plan in which you currently participate:

Name of TennCare Plan

1. _____
2. _____
3. _____
4. _____
5. _____

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ☐ NO ☐

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME

DATE

DESCRIPTION OF
VIOLATION

DESCRIPTION OF
ACTION

1. _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)

YES ☐ NO ☐

2. _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)

YES ☐ NO ☐

3. _____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)

YES ☐ NO ☐

Practitioner's Name _____ License # _____
 Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ☐ NO ☐

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

2.	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

3.	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ☐ NO ☐

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

2.	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

3.	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ☐ NO ☐

Practitioner's Name _____ License# _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s):

YES ☐ NO ☐

DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1. _____ If "YES", is this conviction under appeal? (attach copy of notice of appeal)	_____	_____ YES <input type="checkbox"/> NO <input type="checkbox"/>
2. _____ If "YES", is this conviction under appeal? (attach copy of notice of appeal)	_____	_____ YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____ If "YES", is this conviction under appeal? (attach copy of notice of appeal)	_____	_____ YES <input type="checkbox"/> NO <input type="checkbox"/>

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1. _____	_____
2. _____	_____
3. _____	_____

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

TITLE	PUBLICATION	DATE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

(Signature of Provider)
YB/G6019027/RTK-ms.70

Date: _____